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Parental interaction is a prime determining factor in an individual's growth. Complementary relationships of the mother and father within the family: i.e., the bringing together of both the mothering attitude and the expectation of "growing up", contribute to the individual's maturation. Many analysts, realizing the importance of triadic relationships have moved away from a preoccupation with dyadic mother-child relationships in treatment to a broader focus on child and parental interactions. They see the patient as being triangularly related and recognize that the therapeutic relationship affects and is affected by the homeostatic family relationships. This had led to the following trends in analytic psychotherapy: (1) successful use of a "therapeutic couple" (male and female co-therapists) within a group to treat unhappy married couples, (2) increased application of interpersonal interactions and group processes in analytic group therapy, (3) use of analytic psychotherapy of the family as a whole, and (4) use of group, milieu, family, and community dynamics in treatment of mental hospital patients. (LS)

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PARENTAL INTERATION AS A DETERMINING FACTOR IN SOCIAL GROWTH OF THE INDIVIDUAL IN THE FAMILY.

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PARENTAL INTERACTION AS A DETERMINING FACTOR IN SOCIAL GROWTH OF THE INDIVIDUAL IN THE FAMILY[1]

Max Markowitz, M.D.* and Asya L. Kadis**

It is the purpose of this paper to draw attention to parental interaction as a prime determining factor in the socialization of the individual. In it, we join with others in moving away from what may be an obsessive preoccupation with the "mother-child" relationship prototypic of the dyad to a broader focus on the "child-parental interaction" relationship. We believe that parental interaction can promote or impede the development of healthy family relationships.

By a healthy family, we mean one in which each member acts independently as well as interdependently. Each member learns to assert discipline on himself--"I can wait,"--whereas in the unhealthy family, each member regards himself as central--"I must be fed now without regard for any other reality than myself." In the healthy family, separateness or individuation is emphasized and valued in the context of togetherness. This permits the individual to move freely both within the family circle and out of it. All members work productively and co-operatively for the welfare of themselves as well as of the entire family--"It is for my own good that I cooperate." This context permits the evolution and fruition of an individual's needs.

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The family, by virtue of its structure, requires each individual to pass from a dyadic to a triadic way of relating. The individual must become both individual -and group- centered or he may become a destructive force in the family, just as in society. In effect, the family is a microcosmic society in which socialization of the individual is primarily taught and experienced. Since the individual's most formative period takes place in early childhood when he is almost completely subject to family influence, it would seem clear that his development would be affected not only by his interaction with one parent and the other, but also by the ongoing interaction between the parents themselves. It has been the fashion to blame one parent or another for disturbance in child development, and most usually the mother in American society. This has had the effect of justifying the neurotic absence of the American father from the arena of child-rearing responsibility, creating the noxious situation known as "momism," and resulting in marked disturbance of parental interaction. Most importantly, one observes a trend to place all responsibility on the mother, who driven by her neurotic acceptance of this role, tends to become all mother and less sexual partner, to both her own frustration and that of her partner's. The latter, in turn, similarly accepting the over-evaluation of the mother role, abdicates his rightful position as a family force. Thus, he earns his wif'es resentment by shifting the burden of responsibility for child-rearing to her. Repressed dependency needs in the wife are acted-out by projections onto the man of weakness and inadequacy. Unconsciously guilty about his own self-abdication, felt as weakness, he is hurt by the attitude of the wife, and a hostile interaction ensues. Such disturbance in parental interaction provides a poor soil

for the developmental needs of the child.

At this point, it may be useful for us to review theoretically the maturation process from early infancy. It is generally understood that by virtue of being an infant and not having resources of his own, the infant is naturally accorded a special position in the family. His primary biological and physiological demands must be met -- resulting in focus on him. This centrality of the child is an objective reality validated subjectively and incorporated as omnipotence during the period of early infancy. The mother is a necessity to the child, because he cannot feed himself. The infant's natural feelings of omnipotence as manifestations of the undifferentiated ego are promoted because he is cared for by a mother who tries to meet all his needs promptly in the first few months of life.

How the child later learns to face the reality situation of not being central and omnipotent is the beginning either of healthy separation from the mother or of pathological dependence on her.

The mother's anxiety and conflict about her own need for separateness reflect her own unresolved omnipotence problems. This can deter or prevent the development of her capacity to correct the perception by the infant of his omnipotent world. Thus, she may promote and perpetuate fixation in the dyadic relationship through her conflict.

The more mature mother feels free to recognize both the reality situation and the infant's feelings of omnipotence or need for centrality. She is aware that she has other needs - involving her other children, her husband, and herself. The infant cannot monopolize the "all" of her. She gradually must introduce separation experiences which lead the infant to accept the

new reality. At times, he must wait for his needs to be met.

The less mature mother - the one who as a child was not able to let go of her own need for centrality - feels compelled to give the infant her "all." Therefore, any attention to herself, and away from the child, provokes in her feelings of guilt and anxiety. She overidentifies with the child, and places an intolerable demand on herself to give herself completely to him. She projects her unresolved feelings onto him. (I'll show my mother what a good mother is.)" But the the tremendous demand she makes on herself to keep satisfying her child in turn threatens her own need for centrality. Her unresolved dilemma is the genesis of a pathological situation. She feels trapped by the need to give "all" to the child and is full of resentment because of her own unfulfilled needs. This anxiety in herself produces distrust in the child, who feels "She's trying to avoid me, to get rid of me; she doesn't want me; she doesn't care about me." Thus the mother's anxiety is transmitted to the child, and the child therefore clings to the mother all the more as a defense against being abandoned. The development of the child is thus modified into pathological symbiosis.

The symbiotic relationship that develops between the mother and the child can be a healthy one in which the two are both giving and taking. Each, in effect, says to the other, "I can let you go. We are separate entities with separate needs, but we can live together. We can wait to be fed." Or it can be one that is pathological, on a parasitic level, one in which each, in effect, says to the other, "You exist only to feed me."

At the critical points of development such as weaning, toilet-training, etc., the mother's image splits into two elements: one element remains connected with the symbiotic security of the child - "Mother will feed me forever." The

other is linked with the child's experience of losing the love object - "Mother has left me forever; she'll never come back and I'll die." What has actually taken place is the separation which is perceived as a fatal loss; the child feels abandoned and "as if" he has lost his "good mother," his love object, forever. The ego has not yet learned to differentiate.

At this point, the infant truly experiences and becomes aware of the pain of the primary separation anxiety. Here, the actual split takes place into the "good" and "bad" mother images. The mother's problem becomes one of relieving the child's basic anxiety while maintaining her two separate aspects as her composite identity.

The mother is, by her natural proximity, the one who can best afford the child opportunities for such separation experiences in enlarging the scope and horizon of the child's world. This puts a great demand on the mother, who must have developed the capacity to be flexible, to move from her role of mother to that of wife, to that of woman. In turn, this may provide for an enlarged Welthild for the child - it can lead to the acceptance of a triadic relationship and permit the child to give up the mother as the sole gratifying source, as the "magic ever-flowing breast."

Thus, the child and the two separate aspects of the mother make up the primary triangle. The "bad mother" image, so to say, is now identified with separation anxiety and this "bad mother" perception is projected on the prototypic father's existence. "If it weren't for father, my good mother would of course stay with me always." Therefore, the father's entrance into the child's emotional life is associated by projection with the image of the "bad mother" who takes the "good mother" away from the child. "Mother would continue to

play with me if Father didn't come home." (For example, a patient stated: "I recall over and over sitting on my mother's lap. She's either singing a song to me or telling me a story. When we heard Father's car stop in front of the house, Mother would say, 'Here he comes, and our paradise is over.'") This theme of "loss of paradise" is related to the early dyadic experience of the pre-oedipal phase. Its projection as a defense permits the child to keep the "good mother" image as being eternally "good" and allows him to shift the "bad mother" image onto the father.

Hence, the helpless infant feels that he cannot afford to lose the all-giving, all-omnipotent, all-magic mother. Not yet able to give her up, he will defend his fantasy of omnipotence, which he derives from her. He defends himself against his separation anxiety by a denial of the real total aspect of the mother, both good and bad.

This crucial perception, unless corrected, can play a deterring role in the child's development for the pre-oedipal to the oedipal phase, since the father is perceived as the "bad mother," the "intruder," who wants to break up the symbiotic equilibrium in the idealized dyadic pre-oedipal relationship. The correction of this distorted perception of the father figure is vital to the early identification process which is essential for the further sexual development and maturation of the child, be it male or female. The son cannot identify with a father whom he perceives as an enemy or intruder in his symbiotic relationship with the mother; nor can the daughter form an adequate feminine sexual identification since she tends to see men as "attackers" and "abusers" of women.

Parallel with the child's reluctance to accept the place of the father, the father will need to assert and structure his rightful place as a full-

fledged member in the family unit. He will need to be accepted and included in the dyadic relationship as one of the points of a newly established triangle. The father's struggle will depend to a great extent on the degree to which the mother will recognize his right to exercise his role as a father. The mother's over-protectiveness of the child as a reaction formation to guilt can become a hindering factor to the establishment of the father's position. He will need the strength to penetrate and over come resistance to him without becoming destructive to either spouse or child - a formidable task requiring considerable maturity and understanding.

In the course of forming a constructive triadic relationship with <u>both</u> parents, the child tends to resist by forming unconscious alliances with one parent or the other. If one parent sides with him, he believes the other parent must be wrong. For example, if the child aggresses and is reacted to correctively by the father, obviously he will not like it. If mother intervenes protectively, consensual validation in this instance makes father wrong and an "unfeeling monster." If mother supports father, verbally or otherwise, consensual validation is corrective. Because the child is prone to form such an unconscious alliance, he can be "seduced" by a partisan parent into feeling and thinking that this alliance is a correct one.

Where the parental interaction favors alliance formation with one parent, the one perceived as "mothering," the usual result is pathological symbiosis. The perpetuation of this symbiosis into the oedipal phase of development results in repression of autonomous sexuality in its broadest sense since the individual <u>fears</u> its expression through identification with the "aggressor" parent. The latter would actually be the symbiotic parent, usually the mother. For example, the favoring by a mother of a son, while being hostile

and critical of the father, makes impossible the son's identification with his father since such identification would mean equivalent rejection by his mother. In this case, as a defense, castration anxiety is displaced onto the father as its source but is more deeply related to fear of loss of favored position with the mother. Castration, therefore, is essentially self-imposed, a denial of differantiated self since fusion with the symbiotic parent must be maintained.

Because of unresolved problems and conflicts in the parents - problems and conflicts which are carried from their past to the present - unconscious alliances are fostered in the child rather than corrected so that there is not enough reality testing of the dyadic fantasy. This results in a breakdown of the potential for corrective experience.

This pathological family structure of alliances is characteristic of four basic, unhealthy constellations or types of family patterns: father-centered; mother-centered; child-centered; and family-centered. In each of these constellations, the parents project, transfer, and act out the distortions of their past. Any one of these structures can serve as a destructive and inhibiting force to growth and maturation to all family members.

(1) The <u>father-centered family</u> revolves around the father with a centrality problem, around his need for sole importance and constant gratification. This parent may either compete with the mother for the attention and love of their children or compete with the children for the mother ("Take care of <u>me</u>!") At the same time, because he has to go to work to support them, he is resentful toward both the mother and the children, and because of his resentment the children distrust him. Even if they feel the mother's inadequacy, they cannot use him as a mother substitute. In re-enacting his neurotic past -

protecting his children (that is, himself, by proxy) - he may help to create an image of his wife as the destructive witch." As a result of his unresolved needs for centrality he may project these needs onto one of his children: For example, a patient's professed willingness to sell his house so that his son might attend medical school without regard for the welfare of the rest of his family.

(2) The mother-centered family centers around the mother. She may endeavor to represent the "magical mother" who provides all things for all her children, of whom her husband is one. Or because of her own unresolved feelings of centrality, she may compete with the father for the children or with the children for the father. Just as she clung to her own mother as a defense against being abandoned, so she anxiously clings to her husband or to her children. In her need for centrality, she feels and communicates that any show of affection for someone else is an act of disloyalty to her.

(3) The child-centered family is a newer phenomenon in contemporary society but one that is becoming virtually universally recognized as typical of the American culture. The paramount manifestation here is a kind of status-denial by the parents who both overidentify with the child. He is sheltered, protected from siblings as families are kept small, even child-unique, and must have the "best of everything," and no need to face limitations. It is an accepted fact that the American parent feels guilty to deny his child - to say "no" in pleasures, entertainment, elegance of clothes - and is commonly recognized in our society as the "parent on the run." The child-centered family constantly reinforces the original subjective perception of his centrality and omnipotence and bears its ugly fruit especially during adolescence, leading to indulgence in alcohol, narcotics, delinquency, the inability to withstand frustration, the

lack of cooperation with authority, the "drop-out", and the run-away adolescent.

(4) The family-centered family places an unhealthy emphasis on the importance of the family as a unit. The family myth is one of being special and superior, and recognition of this by others is expected. In contrast to the child-centered family, here the individual does not get enough consideration, and no provision is made for the individual to have the right to be one. Only the total family as a unit is endowed with recognition and rights. Any attempt at separation, separateness, or individuation is resented, denied, fought, and is seen as a threat to the total family. The family becomes an entity of one, instead of a group of individuals who make up the family with each member having a right to his own growth and goals apart from the family itself. This is not a major trend in American society but is frequently observed.

The residue of the centrality problems as mirrored in the four basic unhealthy family constellations is repeated, often compulsively, in the choice of a marriage partner. A person with such unresolved problems unconsciously expects his spouse to serve as an idealized parental figure. The neurotic needs of each play into the needs of the other. Each wants and expects the other to care for his or her needs. Feeling the need for this care, each drives or manipulates for it. Husband and wife become more unhappy as they commonly ignore the third point of the triangle, the marriage.

Many such unhappily married persons have the ego strength to seek help for their problems in psychotherapy. They bring their marital problems, their problems of parenthood, and, above all, their neurotic marriage into the light of the therapeutic situation. In their relationship with a single therapist, many such patients resist analysis as their "centrality" needs are

reinforced by the dyadic relationship and thus remain unresolved. In the one-to-one relationship the therapist gives the patient his full attention and in doing so may ally himself with a distorted image of the maternal prototype who gave the child "everything" it wnated and needed. The transference tends to deny the existence of separateness, and is frequently sufficiently denying so as to be refractive to individual psychoanalytic intervention, unrelated to the existence of countertransference phenomena. Even in an analytic therapy group, this transference resistance may persist, the therapist continuing to represent the all-giving mother; indeed, with a single therapist in the group, a patient's need for centrality may at times be heightened.

The group experience, however, is usually a corrective one, in that it stimulates triadic experience. In it, the group members are enabled to regress to their developmental "fixation points" and to relive and relearn. The group context, moreover, is conducive to eliciting infantile transference identifications and dyadic-motivated competition and with it mobilizes the defenses against them. These are exposed to interaction and analyzed. Thus patients in groups have been noted to seek alliance with one co-therapist, excluding the other entirely. In the course of repeated corrective group experiences, the patients gradually learn to clarify interpersonal boundaries, leading to mutual acceptance, understanding and respect instead of resorting to power to maintain their centrality.

On the basis of their experience as co-therapists in therapy groups with married couples, the authors feel that such corrective experience is obtainable more easily, quickly and productively in a group in which co-therapists, male and female, represent an"inbuilt parental prototype." This readily catalyzes and permits the patient to re-experience the early pre-oedipal triangle. The

recognition of this occurrence is of utmost importance. At this point the co-therapists, as parental prototypes, attempt to elicit, expose and subject to analysis the patient's problem and conflict of centrality. The existence of two therapists creates within the group the presence of both the "good mother" and the "bad mother" as a projection target, hence allowing for re-experience of the pre-oedipal triangle. The co-therapists who relate meaningfully with each other, accept each other, accept both differences and similarities, acknowledge their sexual and emotional differences and their differing parental attitudes, can then form a complementary wholeness as a couple to themselves and to the group.

If, as a result of individual or group treatment, one member of a married couple succeeds in overcoming his need for centrality and is enabled to grow and mature emotionally, the neurotic homeostatic equilibrium of the marriage is upset. The spouse, whether in therapy or not, becomes threatened, over-defensive, and the marriage often breaks up, frequently to the regret of both partners. Thus, to save the marriage, psychotherapy for both members of a marriage frequently is desirable so that a spouse can be helped to cope with the homeostatic alteration. In recognizing this, the authors have attempted to test their conviction that simultaneous treatment in a therapy group of married couples will best afford the opportunity to a couple to see their neurotic interaction with each other.

During the course of such treatment, it becomes possible for the co-therapists to discover where the means for individual growth broke down in the original family of each patient. What deterring role in the patient's growth did the interaction of his parents play? For example:

Female patient Mrs. A. accused her husband, Mr. A, of being so irrationally explosive that she feared for her safety. Mr. B. attacked Mr. A.: "You're a

no-good bastard. You're cruel and sadistic." In the past, because of the male therapist's "perceived" disregard of the female therapist, Mr. B. had attacked the male therapist in similar terms, but not with such intensity. In an attempt to be the woman's protector and to earn thereby the reward of being her favorite, he attacked Mr. A. with great intensity, explosiveness, and affect. This was responded to heatedly by Mrs. A. In this transferential acting out, Mr. B. repressed, through his superego attitudes, his own aggression and compulsively played the role he believed was pleasing to the woman. As this hostile interaction seemed to be endless, the female therapist intervened twice, while the male therapist sat by quietly. The verbal exchange was distressing to the female therapist. After her second appeal - "Let's stop this now and understand what's going on here" - the protagonists heard and responded to her. The co-therapists feel that they do not both have to act and feel the same way. Thus, the male therapist felt at this time that it was important for him not to interfere with the heated interaction between the two men and "permitted" the female therapist to act in her own right and to respond in her way to her own concern. Afterwards the male therapist attempted to throw light on the unconscious motivation of Mr. B's compulsive anger: "It's as if you're competing with your father in trying to be a better man in the eyes of your mother by demanding of yourself that you be pleasing to the woman." Mr. B's emphatic response was, "That's right!" In Mr. B's original family, the mother had disapproved of the father's aggression and thus in the oedipal configuration, Mr. B. believed he had obtained his mother's approval by denying aspects of himself that were identifiable with his father. He came to act out a pleasing rolw in relation to women generally and especially to his wife; and she in turn perceived this as a trap as she felt he demanded that she be pleasing to him as well. In the group Mr. B's

acting out was triggered off by Mrs. A. who, in this instance, became Mr. B's transferential mother figure.

Mr. B's displacement from the female therapist onto Mr. A. gave the male therapist an opportunity to ally himself with the observing ego of Mr. B. and thus enabled Mr. B. to react positively without the compulsive, competitive need to resist and reject. Mr. A. stated that the male therapist's alliance and non-interference in the battle made him feel that he was not a"killer" after all but was entitled to his aggression as self-assertion of his natural sexuality. This corresponded to the male therapist's feeling of identification with and support of what Mr. A. was expressing. The aggression was understood as a response to the castration wishes of his wife.

Thus, both Mr. A. and Mr. B. seemed to have experienced the male therapist's acceptance of their aggression as group syntonic and, therefore, family syntonic

The female co-therapist, at the same time, challenged Mrs. A's faulty perception of her father as a potential "killer" of her mother by repeating the question, "Your father didn't kill anybody, did he?" to which Mrs. A. finally unwillingly responded: "No. He didn't even hit anyone in the family." This made her recognize her distorted projection on her spouse.

This example illustrates how both co-therapists, the inbuilt parental prototype, brought about a corrective experience by focusing on the faulty perception and transferential acting out of the protagonists both in the group and in their marital inter-relationships and by linking this with their nuclear family dynamics.

The co-therapists attempt to provide, through their own inter-action in the group, a different experience and milieu - in effect, a therapeutic model of what an effective marriage can be. They permit elicit, even may provoke

aggression, avoiding counter-aggression. Thus they enable the spouse-parent to elicit and express his repressed hostile, angry feelings toward them as parental figures. This permits him to regress to the point of fixation experienced in the original family. Self liberation is gained through reliving and finding acceptance of the repressed "bad" aspect of the self in the co-therapists' presence which seems much more natural than with a single therapist of either sex.

We do not mean in the above to suggest or imply that "ideal" status be given to the interaction of the "therapeutic couple" (parental prototype), i.e., the perfect parents the patients did not have. However, this insight into the impossibility of such ideals and the co-therapists' freedom to react on this basis, become the major therapeutic tool. On the basis of impressive results, though comparatively small in number, the authors feel that there tends to be confirmation for their conviction.

In line with the scope of this scientific meeting, focused on Social Psychiatry, we shall attempt to relate this paper to the broader problems of the health of the community at large. The authors feel the following is an excellent illustration of the thesis of this paper and the expanded social scope to which it can be applied.

Group process techniques were utilized in a Mental Health Consultation Service given to a group of public health nurses serving a population of 255,000 individuals. Anxious and defensive at first, the nurses reacted with dependency demands on the psychiatrist who was the designated group leader, pressing him for direct help. It was clear that they wanted to be nursed, fed with information. As the leader resisted this pressure and group process unfolded, an interesting phenomenon occurred. In the past, the nurses' "main"

focus of attention was placed upon the mother and child, with some references to siblings. There was a sparsity of information on the role-functioning and relationships of the father figure in the household, except for those fathers who were creating disturbances in the family. In the referral forms submitted later in the conference series, the nurses increasingly focused upon, and recorded more data on fathers, describing their role in the family and their contributions to the health and welfare of the family. A few nurses began to establish direct contacts with fathers. In the initial pahse of the program any information on fathers was obtained via second-hand accounts given by mothers. On the whole, the referral forms reflected the nurses' increasing awareness of the importance of the father's role and functions in the family unit, as well as of family interactions in general.*

As the above example shows, more and more workers in various disciplines who have contact with families and their problems should be educated to bring focus to bear on the dynamics of disturbed family patterns.

As workers in the field of analytic psychotherapy, we are aware of two general trends. One is an increasing conviction of defeat, discouragement, and disillusionment. This prompted a prominent analyst like Sandor Rado** recently to predict that psychoanalysis would find its end in the unfolding knowledge of organic brain functioning. On the other side there is a vigorously growing movement which takes analysts away from couches and the cloistered dyadic treatment form and promotes an application of the study

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of interpersonal interaction and group processes in analytic group therapy. Developing knowledge of the latter trend, in turn, has led to another flourishing offshoot - analytic psychotherapy of the family as a whole.

Nowadays, the experience and awareness of group and family dynamics have led to a revolution in the treatment of the mentally ill. The importance of maintaining the patients' relationship to their families while being treated has led to the mushrooming growth of open door hospitals, day and night hospitals, and day care centers so ably pioneered by Joshua Bierer.* A shift has taken place in treatment approach in our mental hospitals: from one which was essentially custodial in attitude and practice - that is mothering - to a more wholesome one of providing shelter while expecting the patient to maintain relationship with external reality - group treatment, work and contact with fmaily and community. Pills alone - like love alone - are not enough. It is as if the father is now present in the relationship of the child to the mother, the sheltering institution, and thereby creates the necessary pressures tending to expose and break into the symbiotically incestuous patterns of the patient.

The authors feel that an analogy can be made in terms of the theme of this paper which focuses on the importance of the complementary relationships of the mother and father in the family situation - that is, the bringing together of the mothering attitude on the one hand and the expectation of "growing up" on the other.

Various efforts in group approaches to patients and their families in therapeutic communities are now being practiced. The authors are among those

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analysts who see the patient as being triangularly related, needing to be so related, and recognizing that the therapeutic relationship affects and is affected by the homeostatic family relationships. Our experience of treating the married couples in a group with two co-therapists, male and female - the built-in parental prototype - is but one of many successful family treatment approaches.

There are analysts who will level the charge of being anti-analytic at those who have so enthusiastically pioneered or espoused these new approaches. However, there are still those who dare to individuate and grow, to establish ideas of their own. They can, if so minded, hurl the counter-charge of incestuous controlling behavior at those who resist self-realization and growing away from parental dictum. We believe with others that our focus on parental interaction as a determining factor in social growth is analytic, adding further to the analytic lore. Moreover, the passage from dyadic to triadic behavior is analogous to the positive resolution of the œdipal struggle, which promotes freedom and growth. We feel strongly that it is time to de-emphasize the child-mother and child-father relationships in favor of a closer scrutiny of <u>child parental interaction</u> relationships.

Psychoanalysis will yet make its greatest contribution, not as an elite form of psychotherapy, but as the formidable scientific tool that Freud, Jung, and Adler intended it to be: a corrective force in social life.

Finis